RESET

SELF INSURED EMPLOYERS' TIME LOSS CLAIM CLOSURE ORDER AND NOTICE

CLAIM	DATE OF INJURY	UBI NUMBER	MAILING DATE	TYPE **EC**

CLAIMANT

PHYSICIAN

THIS ORDER CONSTITUTES NOTIFICATION THAT YOUR CLAIM IS BEING CLOSED WITH SUCH MEDICAL BENEFITS AND TEMPORARY DISABILITY COMPENSATION AS PROVIDED TO DATE AND WITH SUCH AWARD FOR PERMANENT PARTIAL DISABILITY, IF ANY, AS SET FORTH BELOW, AND WITH THE CONDITION THAT YOU HAVE RETURNED TO WORK WITH THE SELF-INSURED EMPLOYER. IF FOR ANY REASON YOU DISAGREE WITH THE CONDITIONS OR DURATION OF YOUR RETURN TO WORK OR THE MEDICAL BENEFITS, TEMPORARY DISABILITY COMPENSATION PROVIDED, OR PERMANENT PARTIAL DISABILITY THAT HAS BEEN AWARDED, YOU MUST PROTEST IN WRITING TO THE DEPARTMENT OF LABOR AND INDUSTRIES, SELF-INSURANCE SECTION, PO BOX 44892, OLYMPIA WA 98504-4892 WITHIN SIXTY DAYS OF THE DATE YOU RECEIVE THIS ORDER. IF YOU DO NOT PROTEST THIS ORDER TO THE DEPARTMENT, THIS ORDER WILL BECOME FINAL.

TIME LOSS COMPENSATION IN THIS CLAIM IS ENDED AS PAID TO

_____ INCL

THIS CLAIM IS CLOSED EFFECTIVE _____

WITHOUT FURTHER AWARD FOR TIME LOSS OR PERMANENT PARTIAL DISABILITY

NAME OF SELF-INSURED EMPLOYER	IS NOT REQUIRED TO PAY FOR MEDICAL SERVICES OR TREATMENT RENDERED AFTER THE DATE OF CLOSURE.

BY
FOR (NAME OF SELF-INSURED EMPLOYER)
ADDRESS
CITY
PHONE ( )

cc: DEPARTMENT OF LABOR AND INDUSTRIES
SELF INSURANCE SECTION
PO BOX 44892
OLYMPIA WA 98504-4892